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Family Planning Digest

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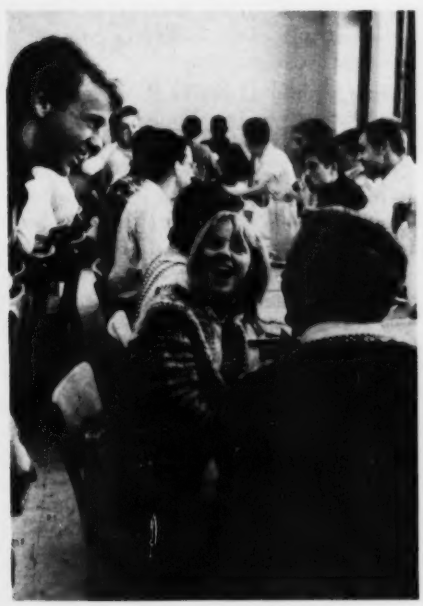
Law

Girls under 18 Can Consent to Birth Control Services in Two-Fifths of the States

By mid-1972, 39 of the 50 states had affirmed the right of unmarried girls who were not legally empancipated and who had reached the age of 18 to consent to their own contraceptive care; and in 19 states they could clearly do so at considerably younger ages, or with no age restriction at all, according to a recent national survey (see Table 1).

The survey was supported by the National Center for Family Planning Services, HSMHA, DHEW. It examined federal and state laws and state health and welfare department policies affecting contraception, family planning, voluntary sterilization and contraceptive and general health services to minors. The study was conducted by Planned Parenthood's Center for Family Planning Program Development.



The survey found "a strong trend" in recent years for states to pass legislation "giving minors access to effective birth control services on their own consent and initiative." While states do not expressly prohibit the provision of contraceptives to minors, young people have often had great difficulty in obtaining medical contraceptive services because of the old common law rule requiring the consent of a parent or guardian before a doctor could treat a minor for anything. Doctors felt that to treat minors without such consent might expose them to suits for technical assault or malpractice, making them liable for damages, and possibly to criminal charges as well.

There were always exceptions to the old common law rule, such as emergency treatment and treatment of legally emancipated minors. What is more, no case has been found in which either a doctor or a layman has been successfully prosecuted criminally or held liable for damages for providing contraception to a minor without parental consent. Nevertheless, doctors, hospitals and health agencies have been reluctant to proceed without specific legal protection.

The survey found that states in recent years have been providing such specific legal protection, both through legislative enactments and court decisions. Increasingly, the survey found, ". . . the federal government and the states have recognized the rights of mature minors to make their own decisions about their lives generally, and about their medical care in particular."

The courts and state legislatures were found to "have gotten away from the old common law rule . . . through the exception for emergency medical treatment of minors . . . the doctrine of the emancipated minor and by new exceptions for

the mature minor and the abused and neglected minor. In addition, numerous statutes have been enacted giving broad categories of minors the right to consent to medical services in general and to contraceptive services in particular."

So far as emergency treatment of minors is concerned, courts throughout the country have held that a physician need not wait to obtain parental consent where an emergency "endangers the life or health of a minor." Twelve states have codified this principle into statutes. Contraceptive services might fall into the emergency category, the study suggested, if "failure to provide . . . service is likely to result in a pregnancy" which may endanger the life or health of the minor or the child who might be born. Support for this argument, the study pointed out, may be found in numerous data documenting the increased risk to the life and health of mother and baby of births to teenagers.

Emancipation

Similarly, the study found, "most courts would hold that a completely emancipated minor can consent to his or her own medical treatment," and the legislatures of at least 21 states have enacted statutes declaring that emancipated and/or married minors can effectively consent to medical care. Marriage and entering into military service have been held to emancipate minors in almost all states. And minors are generally deemed emancipated if they live apart from their parents, support themselves and control their own lives. In some states minors are held emancipated if they live apart from their parents even though their parents still support them. And other states have held that minors are emancipated even though they live with their parents if they work and keep some of their own earnings, or make most of the major decisions affecting their own lives. Some states protect doctors who treat minors from liability if they reasonably rely upon the minors' representation that they are emancipated, even if this turns out not to be true.

Since minors may be partially emancipated for particular purposes, including consent to medical services, the study indicates they may, in some circumstances, be partially emancipated to give consent for contraceptive services.

Mature Minor Rule

A more recent exception to the common law rule has become known as the "mature minor rule," and provides that "a minor can effectively consent to medical treatment for himself if he understands the nature of the treatment and it is for his benefit." This rule has been incorporated into the Mississippi statute and, in effect, has been recognized by the New Hampshire legislature. Kansas, Ohio, New York, Michigan and Washington courts have also acknowledged this rule in regard to medical treatment of minors.

Almost all states, the survey found, have statutes which provide for medical treatment of neglected or abused children, usually holding that the courts may order medical care for such children where the child's health, safety or welfare requires it.

At least 11 states (California, Colorado, Florida, Georgia, Illinois, Kentucky, Maryland, Mississippi, Oregon, Tennessee and Virginia) and the District of Columbia have enacted statutes specifically authorizing doctors to give birth control without parental consent to all minors or to broad categories of minors. Eleven other states have laws authorizing publicly sponsored family planning programs which may permit services to at least some minors without parental consent. In seven of these states (Iowa, Michigan, Nevada, New York, Ohio, West Virginia and Wyoming), the health or welfare departments report provision of contraceptive services to minors without parental consent (see Table 1).

Since passage of the twenty-sixth Amendment allowing 18-year-olds to vote, there has also been "a strong nationwide trend" to reduce the age of majority to 18. The survey pointed out that Arkansas, Idaho, Nevada, Oklahoma and Utah had long differentiated between males and females, providing by statute that females reached majority at 18, males at 21. But more recent statutes have reduced the age of majority to 18 for both sexes in 19 states (Arizona, Connecticut, Delaware, Illinois, Kentucky, Maine, Michigan, New Jersey, New Mexico, North Carolina, North Dakota, South Dakota, Tennessee, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming*). Alaska and Montana have lowered the age of majority to 19, and Nebraska to 20. In Delaware, Illinois and Oregon, 18-year-olds now may enter into binding contracts; while a Washington statute provides that all persons of 18 are deemed of full age for most purposes, including consent to medical services.

In addition, 11 states (Colorado, Connecticut, Georgia, Illinois, Maryland, New Jersey, New York, North Carolina, Pennsylvania, Virginia and Washington), have specifically reduced the age of consent to medical services to 18. It has been reduced to 16 in South Carolina, to 15 in Oregon and to 14 in Alabama. In Louisiana, a minor of any age may consent to medical treatment if he believes himself to be ill. In Kansas, a 16-year-old may consent to medical care when no parent is available; and in Mississippi, Ohio, Michigan and New Hampshire any minor may consent who is "mature." Twelve states (Alabama, California, Colorado, Georgia, Illinois, Kentucky, Louisiana, Maryland, Minnesota, Mississippi, North Carolina and Pennsylvania), have enacted

*Subject to referendum.

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statutes regarding comprehensive medical care of minors.

One of the first areas of state action permitting minors to consent to their own medical care was for diagnosis and treatment of venereal disease. Forty-eight states and the District of Columbia now permit minors to consent for their own VD care; in more than half of these states, enabling legislation has been enacted since 1968 and, according to the survey, "similar developments in the law giving all minors the right to consent to contraceptive services seem in process," supported, as in the case of the VD legislation, by medical endorsement from such groups as the American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics and the American Academy of Family Physicians. Most recently, the U.S. Commission on Population Growth and the American Future strongly endorsed state legislation giving

Table 1. Ages under 21 at Which State Legislation, Court Action, Attorneys General's Opinions and Health and Welfare Department Policies Affirm the Right of Certain Categories of Minors to Consent for Their Own Medical Treatment, for Medical Care in General, for Contraceptive Services and for Examination and Treatment for Pregnancy and Venereal Disease; and Age of Majority (X=Any Age)

State	*Age Majority ((21)*	*May Consent for Medical Care in General*			*May Consent for:*			*Policy for Contraception*	
		No Limitation	*Married (M) or Emancipated (E)*	*In Emergency*	*Contraception*	*Pregnancy connected care*	*VD care*	*Health Dept.*	*Welfare Dept.*
Ala.		14	E,[9]M	X		X	X	X	
Alaska	19,MF				[11] [12]	15[17]	X	19	19
Ariz.	18		E,M	X[10]			X	18	18
Ark.	18F						X	18F[23]	18F
Calif.	18&M[1]		15E[6]M	X	15[13]	X	12	X	X
Colo.		18	15E[6]M		X[3]		X	X	X
Conn.	18	18	E,M				X[18]	18[26]	[25]
Del.	18		E,M			12	12	18[23]	X
Fla.	M		E,M	X	X[20]		X		
Ga.		18[3]	M[3]	X	XF[14] [3]	X[14]	X	X	X
Hawaii	20					14	14	20	20
Idaho	18F						14	18F[23]	X
Ill.	18[1]	18	M[7]	X	X[15]	X	12	X	X
Ind.			E,M	X			X	[25]	
Iowa	M		E,M	X			16	[25]	X[22]
Kans.	18&M[1]	X[4],16[5]			[12]	X	X	18[22]	
Ky.	18		E,M[8]	X	X[3] [14]	X[14]	X	18	18
La.	M	X[21]	M	X	[12]		X		
Maine	18		E	X			X	18[23] [24]	18
Md.		18	M[8]	X	X[3]	X	X	X	[23]
Mass.				X			X[19]	[25]	
Mich.	18	X[4]	E,M	X	[12]		X	X	18
Minn.			E[6],M[8]	X		X	X	[25]	X
Miss.		X[4]	E,M	X	X[16]	X	X	X	
Mo.			E,M[8]			X[14]	X	[24]	
Mont.	19		E,M[7]			X	X	19[23]	19
Nebr.	20,M		M				X	[25]	X
Nev.	18F		E,M	X[10]	[12]		X	18F[23]	X
N.H.		X[4]	E,M				14	X	18
N.J.	18	18	E,M[7]			X	X	[25]	X
N.Mex.	18		E,M	X[10]		X[17]	X	[25]	X
N.Y.		18	E,M[8]	X	[12]		X	[25]	X
N.C.	18	18	E,M	X			X	18	X
N.D.	18		E,M				14	[25]	18
Ohio		X[4]					X	X	
Okla.	18F		E,M	X	[12]		X	18F	18F[23] [24]
Oreg.	18[1],M	15	M		15[14]		12	X	
Pa.		18	E[9],M	X		X	X	[25]	X
R.I.			E	16,M			X		
S.C.		16	E,M	X			X	X	
S.D.	18		E,M				X	18	18
Tenn.	18				X[3]		X	X	18
Tex.	M		M	X			X		X
Utah	18F,M		M	X		X	X	18F	18F
Vt.	18		E,M				12	[25]	X
Va.	18	18[3]	E		X[3] [14]	X[14]	X	X	X
Wash.	18	18	E				14	X	X
W.Va.	18			X	[12]		X	X	X
Wis.	18		E,M					[25]	
Wyo.	18[2]				[12]			[25]	X
D.C.					X	X	X[19]	X	X
Total	**35**	**20**	**40**	**27**	**12**	**20**	**49**	**32**	**36**

Note: The fact that no affirmative legislation, court decision or attorney general's opinion or policy has been found in a particular state does not mean that it is not permissible in that state to provide contraceptive services to some categories of minors on their own consent. For example, it is likely that every state would recognize the right of emancipated and married minors to consent to receive services, and of the physician to render services without parental consent, in an emergency, and health and welfare departments do, in almost all cases, offer services to minors upon their own consent if they are emancipated and/or married.

M = Married
F = Female
E = Emancipated

1. For purposes of signing contracts.
2. Subject to referendum November 1972.
3. Excluding voluntary sterilization.
4. If mature enough to understand the nature and consequences of the treatment. See discussion in text of the "mature minor doctrine." This is a new doctrine and the fact that there is no case or statute in a state affirming it does not mean that it would not be accepted in that state.
5. If parent not immediately available.
6. Emancipated defined as living apart from parents and managing own financial affairs.
7. And/or pregnant.
8. Or parent.
9. Emancipated defined as a high school graduate, a parent or pregnant.
10. If no parent available, others may consent in loco parentis.
11. Information only.
12. Comprehensive family planning law permits (or does not exclude) services to minors without parental consent.
13. If a present or potential welfare recipient.
14. Excluding abortion.
15. If referred by clergyman, physician or Planned Parenthood or if "failure to provide such services would create a serious health hazard."
16. If referred by clergyman, physician, family planning clinic, school or institution of higher learning, or any state or local government agency.
17. Examination only.
18. In public health agencies, public or private hospitals or clinics.
19. In publicly maintained facilities.
20. If married or pregnant or "may suffer, in the opinion of the physician, probable health hazards if such services are not provided." Surgical services excluded.
21. If minor "is or believes himself to be afflicted with an illness or disease."
22. But parental consent "desirable."
23. If had out-of-wedlock children.
24. If had previous pregnancy.
25. Policy locally determined.
26. Or if "head of a family."
27. Except for an operation not essential to health or life.

teenagers the same right to consent to contraceptive services as is enjoyed by adults.

At least 17 states now provide specifically that minors may consent to medical and surgical treatment related to pregnancy. While this has been held by a court in at least one state to include therapeutic abortion, it is not clear to what extent "treatment related to pregnancy" will be construed to include contraception, i.e. the prevention of pregnancy. The one judicial statement found on this question was that the prevention of pregnancy is not included.

The survey found no case in which a doctor was held liable for providing contraceptive services to a minor without parental consent, and no case holding him liable for "supplying *any* medical service to a minor without parental consent where the minor was older than 15 and the treatment was for the minor's benefit and performed with the minor's consent." Neither did the survey find any case where a doctor or health facility treating a minor without parental consent was prosecuted for assault or for endangering the welfare of a minor. Two cases where laymen were charged with distributing or displaying contraceptives to minors were held without merit. In sum, the authors of the study found that "there seems little likelihood of prosecution of physicians or other authorized persons who provide minors with contraceptive information or services."

The survey found that 28 states have statutory provisions regarding confidentiality of at least some medical services to minors (mostly pertaining to VD treatment). Four provide that the physician who treats a minor must notify the parents; 16 specify that he *may* notify them. Most states, however, do not have statutes applicable to the confidentiality of contraceptive services to minors, and provide "no clear guide for the physician as to the extent to which he may or must respect the confidence of the minor for whom he provides contraceptive services."

The survey pointed to decisions by the U.S. Supreme Court and lower courts that "children are 'persons' within the meaning of the Bill of Rights." Only in one such case, in Utah, however, has there been a specific determination that minors 14 and older have a constitutional right to request and consent to medical contraceptive services.

The survey found that 37 state health agencies and the District of Columbia had some type of written or unwritten policy on eligibility of minors for family planning services. Seventeen of these states and the District of Columbia authorized services to minors of any age on their own consent (see Table 1). The rest imposed restrictions based on age, marital, previous pregnancy or parenthood status, or left determination to local jurisdictions. Similarly, welfare departments in 21 states and the District of Columbia indicated that they provided medical services or referrals to all minors without restrictons, while 30 states imposed restrictions of varying kinds.

In Massachusetts and Wisconsin, welfare policy barred services to unmarried persons, apparently on the basis of state statutes. The Massachusetts law has since been declared unconstitutional by the U.S. Supreme Court — a decision which would appear to cast doubt on the constitutionality of the Wisconsin law also. Connecticut and Maryland also forbid all services to unmarried, unemancipated persons, on the basis of administrative policies which "appear to be inconsistent with the federal regulations," according to the survey.

The survey found that social eligibility requirements mandating that individuals be of "a stated age, be married, have children, have been pregnant, or give evidence of veneral disease . . . severely limit access to family planning services to certain types of minors." It found that "the trend toward removal of such restrictions by state legislatures, health departments and welfare agencies" shows that state officials increasingly have come to realize that such restrictions do not "have the intended result of discouraging behavior regarded as undesirable," but rather expose minors to "the manifold risks of unexpected or unwanted pregnancy." [For a related story, see "28 Percent Had Sex; Half Risk Pregnancy," *Digest*, Vol. 1, No. 5, 1972, p. 6.]

Sources

National Center for Family Planning Services, HSMHA, DHEW, *Contraception, Family Planning and Voluntary Sterilization: Laws and Policies of the United States, Each State and Jurisdiction*, U.S. Government Printing Office, Washington, D.C., 1972 (in press).

Family Planning Reporter, Vo. 1, No. 1, 1972.

Manpower

Medic Use Cuts Vasectomy Costs

The utilization of army medics in a California health department vasectomy program is one innovative response to the growing demand for male contraceptive sterilizations in the United States.

Each of the two vasectomy clinics sponsored by the San Bernardino County Health Department utilizes a medic to prepare and drape the patients so that they are ready for the procedure when the urologist arrives. "He merely changes his gloves and walks from one room to the next," reported Dr. Philip Savage, Family Planning Project Director.

Dr. Savage performs the vasectomies himself in one clinic, while in the other a urologist is in charge with three general surgeons under his direction. The physicians are paid $40 an hour, for which, Dr. Savage observed, "we get quite a few vasectomies."

Twenty-four vasectomies are performed per week in three sessions at the two clinics, according to Dr. Savage, who noted that more than 1,000 operations have been performed since August 1971. He estimated that the total cost of the health department's vasectomies comes to $58-$60 each, compared to the usual fee of $125 charged by private physicians in the community.

The medics, who are paid $2.35 an hour, assume their actual clinical duties after observing two sessions (each session lasts two hours) and receiving instruction in sterile techniques. They are responsible for setting up the clinics before the surgeons arrive and cleaning up after they leave.

Dr. Savage and a mature nurse trained by him do all the counseling. "We have an excellent 20-minute film which discusses and explains tubal ligation and vasectomy and is shown to husbands and wives," Dr. Savage explained. This is followed by one-half hour of group discussion. "I emphasize the irreversibility of the procedure, and try to make the candidates understand that they cannot change it later," the physician said. "I also emphasize that there will be no ill effects on their sexual life. Patients may have a private interview if they wish, but when an applicant for a vasectomy doesn't meet our criteria, we insist upon a private interview. We serve only people who cannot afford to pay a private fee, and men applying for the surgery should generally be at least 25 years old, give evidence of a stable marriage and have two or more children." Exceptions are made by the director for various reasons, such as known hereditary disease. The vasectomy is performed six weeks after the counseling.

Reasons cited by the first 300 patients for seeking vasectomies were:

- side reactions and undesirable symptoms from birth control methods, 29 percent;
- apprehension as to effects of pills or IUD, 15 percent;
- worry as to efficacy of other methods of birth control, 23.5 percent;
- one or more unplanned babies resulting from method failure, 14 percent;

- cardiovascular reasons, 4.5 percent;
- difficulty with last pregnancy, 5.5 percent;
- fears as to Rh factor incompatability, 4.5 percent;
- diabetes, two percent;
- uterine fibroids and ovarian cysts, one percent; and,
- not clearly indicated, one percent.

Sixty-seven percent of the vasectomized men were between the ages of 25 and 34, while 10 percent were younger (between 20 and 24) and 23 percent were older. Forty-five percent had been married between six and 10 years; just under 30 percent had been married between one and five years and 17 percent for 11-15 years. About 80 percent of all patients had had two to four children. The 2.5 percent with only one child "had special indications such as hereditary problems or extreme emotional disturbance," according to Dr. Savage.

In the first few months more than 90 percent of the patients "appeared because of the activities of public health nurses working in the department's well-baby and family planning clinics," he said. Since then, about 80 percent have heard about the vasectomy service from public health nurses or from previous patients. Only seven percent are referred by private physicians and only two and four percent, respectively, by the county hospital or welfare department.

The ethnic origin of the men matches closely the ethnic composition of the county. Thus, 81 percent of the patients are Caucasian, while this group comprises 81.8 percent of the population; three percent of the patients are black, while blacks make up 4.3 percent of the population; 15 percent of the patients are Mexican Americans, and this group makes up 12 percent of the population.

Source

P. Savage, "Survey of the First 300 Vasectomies Performed at a Health Department," speech presented at a meeting of the California Interagency Family Planning Council, San Francisco, Nov. 1971, and personal communication.

Prenatal Care
2 in 5 Md. Mothers Need Clinic Services

The extent to which women may be dependent upon organized programs for family planning care is suggested by a study of the source of prenatal care for all mothers who gave birth in Maryland in 1968. Sixty-two percent of the mothers received prenatal care from private physicians, while almost all the rest depended on hospital and health department clinics for such services, indicating that they did not have access to private physicians during their pregnancies.

Three-quarters of white mothers received prenatal care from private physicians, but less than one-fourth of nonwhite mothers had access to such services. More than half of the nonwhites (50.7 percent) went to hospital clinics, and one-fifth (19.8 percent) depended on health department clinics. The study covered 57,000 births, and noted that there was no prenatal care of any kind for about one percent of all white births and about four percent of nonwhite births.

The author of the study, Ira Rosenwaike, Biostatistician with Maryland's Department of Health and Mental Hygiene, held that socioeconomic status "appears to be predominant" in accounting for the different utilization patterns observed. Measuring socioeconomic status by educational attainment and classifying mothers with 11 years or less of schooling in the lower-status group, he found that about half as many mothers of lower socioeconomic status saw private doctors as did higher-status mothers. Except for college graduates, however, fewer black mothers had access to private doctor care than did white mothers of the same educational group. Births to lower-socioeconomic-status mothers comprised 37 percent of all Maryland births — 30 percent of white and 55 percent of nonwhite births.

Early prenatal care is associated with less maternal morbidity, less prematurity and less infant mortality and morbidity. The Maryland study showed that while 82 percent of mothers who saw private doctors started prenatal care in the first trimester of pregnancy, only 41 percent of hospital clinic patients and 30 percent of health department clinic patients did so. Twelve percent of hospital clinic patients and 18 percent of health department clinic patients did not get medical attention until the last trimester of their pregnancies, compared to the less than two percent of private patients. Prenatal care was secured from private physicians least often by younger mothers: Only 47 percent of white and nine percent of nonwhite mothers under 18 received such care. This probably reflected a differential in parental income, Rosenwaike concluded.

Of the more than 6,000 women eligible for financial aid for medical care under Maryland's Medical Assistance Program, "an overwhelming share . . . received prenatal care from hospital or health department clinics; conversely only about one-tenth saw a private physician," Rosenwaike stated.

If a woman does not have access to a

private doctor for prenatal care and delivery, it is not likely that she will visit a private doctor for postpartum care and family planning following delivery. Thirty-six percent of the mothers in Rosenwaike's study used hospital or health department clinics for their prenatal care, or had no prenatal care at all.

Source

I. Rosenwaike, "Sources of Prenatal Care of Mothers Having Births in Maryland," *American Journal of Public Health*, **62**:186, 1972.

Nearing Replacement

Birthrates and fertility rates continue to fall, according to recent data from the National Center for Health Statistics. In the first seven months of 1972 there were 1,869,000 births in the United States — about nine percent fewer than for the first seven months of 1971. The birthrate for this period was 15.5; the fertility rate, 72.7. These were 10 and 11 percent lower, respectively, than for the first seven months of 1971.

Substantial declines were registered for the entire 12-month period ending with July 1972 compared with the corresponding period in 1971, with eight percent fewer births, a nine percent decline in the birthrate and a 10 percent decrease in the fertility rate.

The fertility rate for the first seven months of 1972, if continued throughout couples' reproductive lives, is consistent with population replacement, which could lead eventually to a stabilized population.

Source

National Center for Health Statistics, HSMHA, DHEW, *Monthly Vital Statistics Report*, Vol. 21, No. 7, 1972, p. 1.

Young AFDC Mothers

3 in 10 Get Family Planning Assistance

Between 1969 and 1971 the proportion of welfare mothers of childbearing age receiving Aid to Families with Dependent Children (AFDC) who were provided with medical family planning services declined from 11.7 percent to 8.9 percent. This proportional decline occurred despite the fact that the total number of AFDC mothers who received these services rose over the two-year period from 156,900 to 190,500. These data are derived from the biannual studies of AFDC clients published by the Social and Rehabilitation Service (SRS) of DHEW.

The survey also found a marked rise in the number of women who received family planning information but no medical service — up from 323,400 to 460,400; again, however, there was a drop in the proportion of mothers of childbearing age who received information, down over the two years from 24.1 percent to 21.6 percent.

The decrease in the proportion of mothers of childbearing age who received family planning services is due to the disproportionate increase of younger mothers in the AFDC program during the two-year period. Between 1969 and 1971 the number of welfare mothers of reproductive age jumped from 1,341,300 to 2,132,500, while the median age of all AFDC mothers dropped from 32.2 years to 30.7 years. In 1969, AFDC mothers under 20 years old accounted for 6.6 percent of the total; in 1971, 7.2 percent. The proportion of mothers between 20 and 24 years old rose from 16.7 to 20.2 percent; and those between 25 and 29 years old rose from 17.6 to 18.7 percent. Correspondingly, the percentage of AFDC mothers over 30 declined.

Nevertheless, the SRS report singled out family planning as one of the "top group of services received by at least one in four families in 1971." Other services in the "top group" were: medical and dental care, provided to 38.9 percent of AFDC families; home improvement and financial management assistance, to 37.1 percent; services to secure support of children, 28.4 percent; and better or improved housing conditions, 27.2 percent.

Other highlights of the demographic profile were:

- While the percentage of white AFDC families increased slightly in the two-year period — from 48.1 percent to 48.3 percent — there was a decline in the percentage of black AFDC families — from 45.2 to 43.3 percent.
- In 1969, 48.1 percent of AFDC recipient children were black, compared to 44.8 percent who were white. By 1971, a proportional increase of white children relative to black children practically equalized the proportions of the two groups — 45.6 percent, black to 45.4 percent, white.
- Between 1969 and 1971, AFDC families reporting *no* illegitimate recipient children rose from 54.9 percent to 56.5 percent.
- The percentage of AFDC children living with both natural parents increased from 68.3 percent in 1969 to 71.3 percent in 1971. The percentage of AFDC children living with two or more different mothers or fathers declined in the same period from 31 percent to 27.6 percent.
- The median number of children in AFDC families declined from 3.0 in 1969 to 2.8 in 1971, revealing a distinct trend toward smaller AFDC families. Further evidence of the trend is shown in the decrease in the median number of persons in each assistance group, from 4.1 in 1969 to 3.9 in 1971.
- Whether AFDC families had one household head or two, there was the same overall decline in family size. For instance, the median number of children in families with one adult recipient fell from 2.02 in 1969 to 1.83 in 1971. Where there were two adult recipients the median number of children declined from 2.9 to 2.5.
- The length of time on assistance has become shorter for the average AFDC family, and there are more first-time recipients. In 1969, the median length of time on AFDC was 1.9 years; in 1971 it dropped to 1.6 years. In 1969, 59.7 percent of AFDC families had not received previous assistance; the 1971 survey showed that 65.8 percent were first-time recipients.
- The 1971 survey indicates that 16 percent of AFDC families are of Latin American birth or ancestry, the great majority being either Puerto Rican (7.4 percent), or Mexican American (5.2 percent). [For another report on families receiving welfare assistance, see *Digest*, Vol. 1, No. 4, 1972, p.3.]

Sources

National Center for Social Statistics (NCSS), Social and Rehabilitation Service (SRS), DHEW, "Findings of the 1969 AFDC Study: Data by Census Division and Selected States, Part I. Demographic and Program Characteristics," U.S. Government Printing Office, Washington, D.C. (GPO), 0-413-841, 1971.

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Abortion Warning

Dilatation May Add To Miscarriage Risk

Vaginal termination of pregnancy accompanied by dilatation of the cervix may increase the risk of a spontaneous miscarriage during the second trimester of a subsequent pregnancy by as much as tenfold, according to a statistical study by a British physician team.

The study found that during 1971, in Queen Charlotte's Maternity Hospital, London, there was a tenfold increase in the number of second-trimester miscarriages in pregnancies which followed a vaginal termination of pregnancy, compared with all patients who delivered or miscarried in the hospital in the same year, and a ninefold increase compared to an age-matched control group of women who had had an immediately preceding spontaneous miscarriage, but no dilatation of the cervix. As a result of their findings, the physicians recommended that examination of the cervix should be made every two weeks in subsequent pregnancies of women who have had vaginal termination of pregnancy with cervical dilatation.

Drs. Charles S.W. Wright, Stuart Campbell and John Beazley, of the Institute of Obstetrics and Gynecology at the Hospital, checked all 3,314 patients who attended the hospital antenatally and who had deliveries during 1971. Specific questions were asked concerning all previous miscarriages and abortions. The patients were divided into three groups. One group was composed of those 91 patients whose immediately preceding pregnancy had

been terminated vaginally. A second group included 91 age-matched controls who had had one spontaneous miscarriage immediately before their current pregnancy. A third group comprised all the deliveries or miscarriages occurring in the hospital within the one year of the study (excluding the 91 who had had vaginal terminations).

The physicians found that of the 91 women whose pregnancies had been vaginally terminated, eight had spontaneous second-trimester miscarriages in their subsequent pregnancies and one had a clinically incompetent cervix that required a suture. There were no first-trimester spontaneous abortions. Four patients went into premature labor, and there was one intrauterine death caused by blood type incompatability. Of the 91 control patients, one had a spontaneous second-trimester miscarriage and four had first-trimester spontaneous abortions. One patient went into premature labor, and there were no stillbirths. Thus, the investigators wrote in *Lancet*, "there was a statistically significant increase in the number of second-trimester [spontaneous] abortions" in the group which had cervical dilatation in connection with induced abortion as compared to those who had spontaneously miscarried.

There were 30 spontaneous second-trimester miscarriages, or an incidence of 0.9 percent in the third group of 3,223.

The researchers claimed that their belief "that temporary or permanent cervical incompetence is induced by the procedure of dilatation of the cervix during termination" was "further suggested by the fact that a control group had significantly fewer second-trimester abortions. The only important difference between the two groups was that the previous termination patients had had forcible dilatation of the cervix."

They warned that if the nine percent incidence of second-trimester miscarriage indicated in their study is correct, then "an additional 10,000 second-trimester abortions may take place annually in the U.K. over the next few years." They pointed out that all but one of the women who had miscarried in pregnancies subsequent to induced vaginal abortions had been terminated after the tenth week of gestation. They suggested that earlier termination, using such instruments as the Karman cannula, which does not require cervical dilatation, should reduce the risk of cervical damage.

Source

C.S.W. Wright, S. Campbell and J. Beazley, "Second-Trimester Abortion After Vaginal Termination of Pregnancy," *Lancet*, 1:1278, 1972.

Resources in Review

By Dorothy L. Millstone

Family planning is still too young a field to have developed a centralized source of learning materials. Printed and audio-visual materials are being produced in a variety of settings — universities, hospitals, freestanding clinics and health departments, to name just a few — to meet concrete community or agency needs. These materials are intended for professionals and paraprofessionals, for married and unmarried consumers, for the young and for their elders.

This column is looking for such new items. Readers are urged to send their own materials for review. Send two copies of each item; define the intended audience and goal, state the price and how *Digest* readers may obtain copies. Contributions should be addressed to:

Resources in Review
Family Planning Digest
Room 12A-33
5600 Fishers Lane
Rockville, Md. 20852

Selection of an item for use in this column does not imply that it carries the stamp of perfection. Some items reviewed may be put to work elsewhere easily and beneficially; others can be adapted. Some will suggest a useful approach. A few may help planners to decide what they don't want to do. The column's main purpose is to pass on to others in the family planning field the fruits of the recent educational efforts of many individuals and organizations. We can't be all-inclusive, but we will make every effort to call attention to what is fresh, useful and needed.

Meeting Youth's Needs

Until fairly recently there were few materials designed to meet the specific and unique needs of teenagers for family planning information and services. The sexually active young, as well as society, are paying a high penalty for this ignorance. Now, at last, many initiatives are being taken to provide the education so long denied or neglected, and this inaugural column brings a first selection from among these.

For Teenagers

• Film — "I'm 17, Pregnant and I Don't Know What to Do." 20 minutes, color. Pregnant teenagers meet and discuss with each other and with a tactful social worker their many reasons for risk-taking, the range of options they face and the hard decisions they have to make. Young people of both sexes have much to gain from this nonpunitive, quite balanced film.

Purchase price, $200, from the Children's Home Society of California, 3100 West Adams Blvd., Los Angeles, Calif. 90018. Rental, $12.50 for one day, from PP-WP Film Library, 267 West 25 Street, New York, N.Y. 10001.

• Film — "About Sex." 24 minutes, color. Led by an unusually gifted, sensitive, straight-talking counselor from a ghetto background, a group of articulate, honest teenagers work their way toward an understanding of their own sexuality and of society's hangups about sex. Masturbation, pregnancy, birth control, homosexuality, human growth and development — all these are discussed by the young people from their own perspective and out of their own experience, instead of as abstractions. Misinformation is corrected, sex myths discredited. While serious, grace and humor are also part of this teen scene. The film will be particularly useful in stimulating teenage discussion. It is also a fine learning tool for adult counselors who would like to understand young people.

Purchase price, $220; rental, $25, from Texture Films, 1600 Broadway, New York, N.Y. 10019.

• Comic book — "Ten Heavy Facts about Sex." In 20 pages, Sol Gordon, Professor of Family and Child Development at Syracuse University, touches upon sex fantasies, masturbation, homosexuality, venereal disease, worries about size of genitalia, pornography, how pregnancy occurs and how to avoid it. The text is wisecracking; the language an unusual combination of straight and vernacular. The art is in the new comic book style. Comic book aficionados might find this one helpful.

Purchase price, minimum order of 425 for $50; orders above 5,000 at 10 cents each, from Family Planning and Population Information Center, Syracuse University, 760 Ostrom Avenue, Syracuse, N.Y. 13210.

For Adult Counselors

• Filmstrip — 'Right Now, It's a Love Trip." 15 minutes, color. Includes record. Adults get a brief, authentic glimpse into a counseling service run for and by teenagers. Like looking at reality through a one-way window, the filmstrip provides insight into young peoples' attitudes, sexual interests, activities and contraceptive needs.

Purchase price, $25, from PP-WP, Alameda-San Francisco, 2340 Clay Street, San Francisco, Calif. 94115. Rental, $5 for one day, from PP-WP Film Lib-

rary, 267 West 25 Street, New York, N.Y. 10001.

• Handbook — "Right Now, It's a Love Trip." This is a guide for those seeking to establish contraceptive and counseling programs for teenagers. It documents the need for teen service, discusses how to obtain community support and funding, and outlines approaches to operating the birth control program. The handbook examines contraceptive methods in relation to young people's preferences and special needs and takes a look at selecting and training staff. Sample training outlines and a selected reading list are included. Mainly oriented to California, it may be more helpful as a source to adapt from than for direct use.

Purchase price, $2.50 a copy in single orders; $2 each in volume of 50 or more, from PP-WP, Alameda-San Francisco, 2340 Clay Street, San Francisco, Calif. 94115.

For Many Consumer Audiences

The New York State Department of Health's "Planning a Family," is a 16-page, lavishly illustrated pamphlet intended for married couples, and its opening text is headed "A memo to wives and husbands." However, the text is quite simple and would be easily understood by young people and adults with low literacy, married or unmarried. Its message is that families can be planned, that family planning is simple, safe, costs little and is voluntary. The physiology of reproduction is briefly explained and the principal methods are named and described. One weakness may be an even-handed presentation which places all methods on the same level without explanation or comment.

Available *free for New York State residents*, from the New York State Health Department, 84 Holland Avenue, Albany, N.Y. 12208. Nonresidents may write to Publications Department, PP-WP, 810 Seventh Avenue, New York, N.Y. 10019 for a sample copy.

Keeping Abreast

Such a volume of publications relating to family planning and population flows from the printing presses of the world that it is virtually impossible to keep abreast of them systematically without the help of bibliographies. Fortunately, several very good ones are readily available.

• A new, well-chosen, concisely annotated *Bibliography of Family Planning and Population* is now available from the Simon Population Trust in England. The classification is simple, covering 10 subject headings including population and fertility, family planning in general, sex and population education, abortion, reproductive behavior, and specific contraceptive methods. In addition to worldwide coverage of articles and books, administrative reports, conference proceedings, theses and films are listed. An author's index and a geographical index are included.

Photocopies of articles cost 21 cents a page. $18 a year (six issues) or $3 for a single issue, from Simon Population Trust, 141 Newmarket Road, Cambridge C85 8HA, England.

• *Current Publications in Population/Family Planning*, issued in alternate months by the Population Council. Contains abstracts of new books and articles considered to be of particular interest to administrators and scholars.

Available free, from Information Office, Population Council, 245 Park Avenue, New York, N.Y. 10017. (Other useful publications available from the same source: *Studies in Family Planning*, *Country Profiles* and *Reports on Population-Family Planning*, all with more of an international than U.S. focus.)

• The Carolina Population Center recently initiated a new bibliography series. The inaugural publication (May 1972), "Studies Relating Women's Non-familial Activity and Fertility," would be of particular interest to those concerned with the woman question.

The second, issued this summer, is "Basic Reference Sources in Population/Family Planning: An Annotated Bibliography." This bibliography is a useful tool for a student or amateur researcher who wants to make effective use of a university's or large community's extensive library resources. An index of indexes, it provides clues as to what you can find where.

Available free, from Judith Marshall, The Library, Carolina Population Center, University Square, Chapel Hill, N.C. 27514.

• Also worth receiving regularly are the Carolina Population Center *List of Acquisitions*, usually issued monthly; the Planned Parenthood Federation of America monthly list, *Current Literature in Family Planning;* and *Population Index*, published by the Office of Population Information at Princeton University for the Population Association of America.

The first two are available without cost. Order the Carolina Center's list from address given above. For the second, address The Library, Planned Parenthood Federation of America, Inc., 810 Seventh Ave., New York, N.Y. 10019. *Population Index* costs $15 a year and may be ordered from the Office of Population Research, Princeton University, 5 Ivy Lane, Princeton, N.J., 08540.

Family Planning

No Better Preventive Medicine Measure

In England, as in the United States, physicians and local health authorities are being urged to take a more active role in family planning than they now do. In a recent editorial, the *British Medical Journal* urged physicians to accept family planning "as one of the essential public health measures of our day." A similar signed editorial in another prestigious British medical journal, *Lancet*, called on the National Health Service to "formally accept responsibility" for family planning services, stating that "there is no better example of preventive medicine."

The *BMJ* editorial was prompted by three concerns: the mounting number of abortions in England and Wales (86,565 in 1970, rising to 126,734 in 1971), the cost of unwanted children to individuals, families and society, and the impact of overpopulation.

While acknowledging that family planning alone cannot eliminate these problems because "human nature is more wayward than planners are apt to think," the editorial observes: "As a profession, we must admit to being slow in recognizing the needs of our patients for advice and treatment." It asks: "Has the subject yet achieved the place it ought to hold in medical education? Are patients . . . receiving the guidance they want but sometimes scarcely know how to ask for?"

The *Lancet* editorial, by J.K. Russell, called on the government to be responsible for providing "effective family-planning service throughout the country. . . . The aim should be a personal service suited to the needs of the individual and available to all who want to avoid a pregnancy." Russell said that the government must "drop the distinction between medical and social needs. . . ." (Contraception is not given free for "social" indications in Britain.) He points out that contraceptive prescription fees are "quite considerable in the long term [and] may well deter many women from taking the necessary precautions against pregnancy and contribute to the huge number of requests for therapeutic abortion."

Sources

J.K. Russell, "Planning Family Planning," *The Lancet*, 1:310, 1972.

"Vagaries of Parenthood," editorial, *British Medical Journal*, 1:643, 1972.

1970 National Fertility Study

Over 1960s Decade Unwanted Births Decline; Better Methods Adopted; Fertility Gap Between Poor and More Affluent Reduced

Among the richest resources for family planning program planners and administrators are the quinquennial National Fertility Studies (NFS), which elucidate the fertility behavior of married U.S. couples, and the changes over time in such behavior. The following three stories present some of the highlights from the 1970 NFS and from special studies derived from it, as well as a comparison of some of the findings of the 1965 and the 1970 NFS. The data from the 1970 NFS were based on extensive interviews with a national probability sample of 5,884 married women under 45 years of age and living with their husbands. Codirectors of the NFS were Norman B. Ryder and Charles F. Westoff, both of Princeton University's Office of Population Research. Both studies were conducted under contract with the Center for Population Research of the National Institute of Child Health and Human Development.

All Groups Reduce Unwanted Births

U.S. married couples surveyed in 1970 wanted fewer children and were more successful in limiting their offspring to the number they wanted than were similar couples interviewed a half-decade earlier. A 36 percent decline in the rate of unwanted childbearing was attributed primarily to the use of the most effective contraceptive methods — the pill, the IUD and elective sterilization — by married couples of reproductive age. The largest declines in unwanted birthrates were registered by blacks (56 percent) and Catholics (45 percent) — particularly those of low education. Organized family planning programs established since the mid-1960s were credited with having played a significant role in the declines among couples of lower socioeconomic status.

These were some major conclusions from comparisons of the results the 1965 and 1970 NFS. "American couples have changed their reproductive behavior radically over the course of the past five years," Ryder and Westoff reported, "adjusting their fertility goals sharply downward, and increasing substantially their ability to stop childbearing at the wanted level." The authors stated that while "all parts of the population have shared in these developments," declines were greatest among blacks and Catholics — especially those of lower education — "whose [fertility] performance previously deviated most from the national averages."

The authors pointed out:

- "During the course of only five years, the rate of unwanted fertility [defined as unwanted births per 1,000 woman-years of exposure to risk] was reduced by more than one-third" (from 55 to 35).
- Unwanted rates were still twice as high for blacks (65) as for whites (31) in the 1966-1970 period; but the black-white differential was reduced substantially since 1961-1965, when the black rate was three times higher (149 vs. 48).
- The unwanted rate for white Catholics (36) slightly exceeded the non-Catholic rate (29) in 1966-1970, whereas it had been 50 percent higher in the earlier period (66 vs. 43).
- The unwanted rate in 1966-1970 for wives with less than a high school education (43) was almost twice that of college-educated wives (24), and more than one-quarter higher than for wives who were graduated from high school (34); in 1961-1965 the rate for low education wives (81) had been nearly three times higher than for those with college educations (29) and almost twice as high as for those who had finished high school (42).

Between 1961-1965 and 1966-1970, the black rate of unwanted fertility thus dropped by 56 percent, compared to 35 percent for whites; Catholic rates declined by 45 percent, compared to 33 percent for non-Catholics; and the rates for wives with less than a high school education were reduced 47 percent, compared to 17 percent for the college-educated and 19 percent for the high school graduates.

"Undoubtedly, private and public family planning programs have played some role in this change," the authors stated.

In addition to the decline in the unwanted fertility rate, they reported that ". . . a substantial downward revision of future intended births has occurred." This, they said, was particularly marked for the younger married couples who said they wanted an average of 2.5 children, "some 15 percent below the levels recorded for [their] predecessors of only 10 years before." The authors stated that U.S. fertility "would be below the replacement level with one more decade of comparable change."

Decline Due to Better Method Use

In another report based on data from the 1965 and 1970 NFS, Westoff stated that a dramatic increase in use of the most effective methods of contraception — the pill, the IUD and contraceptive sterilization — was "undoubtedly the main

explanation" for the decline in rates of unwanted childbearing over the two half-decades, "and a major factor in the drop in the nation's birthrate" — now at an all-time low.

He pointed out that 58 percent of married contraceptors were using one of these "most effective" methods in 1970, compared to 37 percent in 1965. As in 1965, more than 92 percent of couples who were not pregnant, seeking a pregnancy, sterile or subfecund were currently using some method of contraception. Less than four percent had *never* used contraception for motivational reasons such as indifference.

Among all married couples of reproductive age, the pill was far and away the leading contraceptive, used by 34 percent of the couples (up from 24 percent five years earlier), followed by contraceptive sterilization, used by 16 percent (up from 12 percent in 1965). IUD use increased sevenfold over the five-year period, from 0.7 percent of couples in 1965 to 4.8 percent in 1970. Use of all the more traditional methods — diaphragm, condom, rhythm, withdrawal and douche — declined over the half-decade.

One of the "most dramatic findings" of the 1970 NFS was the fact that voluntary sterilization had become the most popular method of contraception among couples where the wife was 30 years of age or older. Among one-fourth of such couples who were practicing birth control, the wife elected to have a tubal ligation or the husband a vasectomy for contraceptive reasons.

The modernization of contraceptive practice by U.S. married couples has taken place, Westoff pointed out, fairly uniformly among blacks and whites, and among couples of widely varying educational levels. The considerable differences in practice of the most effective contraception shown in earlier studies between women of lower and higher education was nearly eliminated. "The data for 1970 would seem to indicate that low-income couples have almost caught up to the level of contraceptive protection experienced by higher income couples. This is probably in substantial part due to the efforts of public and private family planning programs," Westoff stated.

The adoption of the pill by American women (nearly six million married couples of reproductive age were relying on it in 1970) was described by Westoff as "an amazing phenomenon . . . and is an indication of the wide market for effective contraception." He said most of the increase in pill use "can be attributed to its widespread acceptance by young women."

About half of the contracepting couples with wives under 30 were relying on the pill for protection in 1970 compared with 21 percent of older couples. This contrasts with sterilization, the favorite method of the older couples, but — not surprisingly — adopted by only six percent of the younger couples (with no increase over the 1965 period).

Pill and IUD Young Couples' First Choice

A month-by-month analysis of the adoption of the oral contraceptive and the IUD over almost a decade by married women under 35 years of age indicates that "a revolution in American contraceptive practice" has taken place, according to NFS codirector Norman B. Ryder. In this analysis he also compared marital conception rates with proportions of married couples using the pill between 1961 and 1968. This period coincides, he pointed out, with "the largest decline yet reported for American fertility": a drop of 32 percent in the period total fertility rate (from a synthetic cohort family size of 3.62 children per woman in 1961 to 2.46 in 1968). Ryder found a "moderately strong relationship between the pattern of [pill] adoption and the decline in [marital] fertility," a relationship which he said was no larger than "we should have expected," since reproductive intentions also changed and the pill was usually a substitute for some other method of fertility control rather than a replacement for using nothing to prevent unwanted pregnancy.

As for the IUD, Ryder said the NFS data on rates of increase in the latter months of 1970 "suggest that it may have become by now the second most important contraceptive," after the pill. While three percent of U.S. married couples used the pill in 1961, 31 percent did so in 1969, with a slight decline in 1970 to 29 percent, all concentrated in the early months of the year and attributed to unfavorable pill publicity at that time generated by Congressional hearings (the Nelson hearings). By 1970 the same proportion of black wives as white wives was using the pill, but it took black wives 27 months longer than whites to reach the point at which 20 percent were using this method. Thus, black couples were still increasing their use of the pill in 1970, whereas white couples had reached a peak as of 1967 and plateaued. Because of this differential rate of pill adoption (particularly between black and white couples of lower education), the proportion using the pill in the decade as a whole was 20.7 percent for whites, but only 14.5 percent for blacks. By 1970, however, black wives who had at least completed high school were using the pill in larger proportions than white wives of the same educational level (33 percent vs. 31 percent), and there was no statistically significant difference between black and white wives who had less education. This, Ryder commented, "contrasts sharply with the situation as of the time of our [1965] study, when twice as high a proportion of whites as blacks were using the pill."

Catholics were found to have lagged behind non-Catholics — by 18 months — in reaching the level at which 20 percent of couples used the pill. Data for December 1970, however, showed 29.5 percent of white Catholics using the pill compared with 31.3 percent of white non-Catholics, a similar pattern of convergence over the decade as was noted for blacks and whites. The monthly series of data on pill use showed "no statistically significant decline" among Catholic couples subsequent to the release of the papal encyclical enjoining use of this form of contraception.

For each year, Ryder found that couples who had been married longer tended to use the pill less. Thus, in 1970, 34 percent of wives who had been married four years or less were using the pill, compared to 30 percent of those married five to nine years, and 20 percent of those married 10-14 years. These differentials were much more marked for the white non-Catholic than for the black and white Catholic wives. Ryder concluded, however, that the differences were "primarily indicative of differential receptivity to innovation, and that there is as yet no evidence of a tendency for pill use to decline with advancing length of marriage."

Comparing the decline in the marital conception rate for the eight years 1961-

1968 with the decline in nonuse (that is, increase in use) of the pill, Ryder found that the conception rate declined 43.2 percent for 20-24-year-olds, compared to a 61.3 percent decline in pill nonuse; 25-29-year-olds experienced a 38.9 percent decline in conception compared to a 40.5 percent decline in pill nonuse, and 30-34-year-olds experienced a 39.3 percent conception rate decline, compared to a 24.7 percent decline in pill nonuse. Thus, the decline in the conception rate was less than the decline in pill nonuse for the youngest group, about the same for the middle group and greater for the oldest group. Ryder suggests that this may mean that "in the younger age group, some of the pill use was a substitute for other modes of fertility regulation, whereas in the older age group, other modes of fertility regulation were being employed in addition to the pill."

His data indicate "an approximate pattern of relationship" in the year-by-year declines in the two measures. That is, the declines in the early and the late years were found to be small both for the conception rate and pill nonuse, while declines in the middle years were large for both rates. The pattern, however, he found to be "irregular and imprecise," indicating "an interesting but only moderately strong relationship. . . ."

The IUD

IUD use did not reach one percent among married couples until February 1966, but "the tempo of adoption [since then] has persistently increased," Ryder said. Thus, it took 23 months after February 1966 to reach two percent, 16 months more to reach three percent, just seven more months to reach four percent, only five more months to reach five percent, and just four more months to reach six percent in September 1970. By December 1970, just three months later, IUD use had increased to 6.8 percent, with no signs of plateauing. Thus, while the IUD "is of much less importance than the pill . . . it seems likely to become more important than any of the once-popular premodern methods (condom, diaphragm, rhythm, douche and withdrawal)," he concluded.

While more black wives than white wives used the IUD from 1965 to 1969, the position was reversed by 1970, with 5.9 percent of white wives using IUDs compared to 5.3 percent of black wives. The role of education, however, is reversed in the two groups, with white wives of higher education adopting the IUD in larger proportions than those of lower education; while black wives of lower education use the IUD more often than those with more education.

While Catholics were slower to adopt the IUD than non-Catholics (lagging by about one year), the proportion of the two groups using the IUD had practically converged by September 1970 (6.0 percent non-Catholic to 5.7 percent Catholic); and by December 1970 a higher proportion of Catholics (8.3 percent) than of non-Catholics (6.0 percent) appeared to be using the IUD.

10-13 Million Need Birth Control Help

Despite improvements in availability and use of birth control services, between 10 and 13 million fertile American women still need aid in improving their contraceptive practices to achieve their desired family size. Nearly one-fourth of these women are low-income, with family incomes below 150 percent of the federal poverty line ($5,952 a year for a nonfarm family of four in 1970), and between seven and eight million are married; the rest are single, separated, widowed or divorced.

These are the main conclusions of a special study on delivery of family planning services by Frederick S. Jaffe, Vice President of Planned Parenthood-World Population and Director of the Center for Family Planning Program Development. In his study, made for the Commission on Population Growth and the American Future, Jaffe wrote: "Between 23 and 30 percent of all women of childbearing age appear to be currently practicing methods of fertility control which are inadequate to achieve their [family size] goals and which represent a poor application of existing birth control knowledge and technology." He based this estimate on the proportion of wives reported in the 1970 NFS to be using the least effective contraceptive methods or none at all in 1970.

Depending on assumptions about the extent to which *unmarried* women of childbearing age are exposed to pregnancy risk and the difficulty they have in gaining access to effective medical contraceptives, Jaffe said a "low estimate" of the number of women needing better family planning services ranges from 9.8 to 12 million, and a "high estimate" runs from 10.9 to 13.3 million.

Jaffe analyzed 1970 NFS findings that:

- Between 1965 and 1970, married couples preferred smaller families than did their counterparts in the 1950s and early 1960s.
- Increased use of effective methods by low-income couples reflected the increasing importance of organized family planning programs, spurred by federal funds, as a major source of medical contraceptive care for these couples, as well as for nonwhites and younger married couples, whatever their economic status.
- A larger proportion of both poor and nonpoor couples shifted toward use of the pill, the IUD and sterilization, the most effective contraceptive methods (see: "All Groups Reduce Unwanted Births," p. 9).

While physicians in private practice continued to be the main source of contraceptive care for most U.S. couples, Jaffe pointed out: "As organized programs became more available, utilization has increased." Most physicians in private practice waited to prescribe contraception until their patients initiated the request. While six in 10 wives had had a family planning consultation with a physician at some point in their lives, only one in four reported such consultation at the time of the premarital medical examination.

Jaffe called for a national policy and program: to bring effective contraceptive services to individuals who are now using ineffective or no fertility control methods; to enable these individuals to use effective techniques when first exposed to risk of pregnancy rather than after one or more births, and to provide accurate information about sex, reproduction, pregnancy risk and the availability of family planning services.

The main finding of his analysis of the 1970 NFS, Jaffe said, is "the picture of convergence among all sectors of the married population" on the use of the more effective methods. Nearly half of couples married less than five years used the most effective techniques, with no large differences linked to economic status or color. However, some differentials traditionally associated with socioeconomic status continued: Only 34 percent of all poverty-status couples used the most effective or moderately effective methods, compared to 41 percent of couples above the poverty level. Furthermore, an additional 34 percent of poverty-status couples used less effective techniques or no methods, compared to 29 percent of couples above the poverty level.

In 1970, the average number of children desired by all couples was 2.7, among couples married less than five years it was 2.5.

Improved family planning practices were linked by Jaffe to the trend toward smaller family size in 1970. Couples married after 1966 began using contraceptives earlier and adopted more effective contraceptive methods than did couples married before 1966. For example, 38 percent of couples living below 150-percent-of-poverty who were married after 1966 began using contraception before the first pregnancy, compared to

13 percent of similar couples who were married earlier.

Above 150-percent-of-poverty, the proportion of couples married after 1966 who initiated contraception before their first pregnancy was two-thirds greater than the proportion of couples married before 1966. Despite these striking changes, nearly two-thirds of poverty-status couples and half of those above poverty who married after 1966 did not use contraception until after the birth of the first child, Jaffe noted.

The number of births considered unwanted at the time of conception declined between 1965 and 1970. Still, 15 percent of births in the latter period were classified by wives as unwanted. There was a steep increase by birth order, rising to 35 percent of fourth births, 45 percent of fifth births and 63 percent of sixth and higher birth orders unwanted. Couples below the 150-percent-of-poverty level reported 27 percent of their 1966-1970 births as unwanted, in contrast to 12 percent of births among couples above the poverty cutoff. Nonwhite poverty status couples reported 40 percent of births as unwanted at the time of conception, compared to 23 percent among whites at the same economic level. Above the 150-percent-of-poverty level, the white-nonwhite differential virtually disappears.

Applying the reported incidence of unwanted births in 1966-1970 to the estimated average annual fertility rates during the same period, Jaffe reported:

- The average annual number of unwanted births from 1966-1970 is estimated at between 530,000 and 600,000, a sharp decline from the average of 781,000 annually estimated for the period 1960-1965.
- Two-thirds of these unwanted births occurred to white couples; slightly more than half of unwanted births occurred to couples below the 150-percent-of-poverty level.

Prevention of these births, Jaffe observed, would have reduced the average annual number of U.S. births to three million or less and yielded annual fertility rates of 67-89 wanted births per 1,000 women for white and nonwhite women above *and* below poverty status.

Sources of Contraceptive Services

The 1970 National Fertility Study for the first time asked a series of questions about where married women obtained contraceptive care. By 1970, five out of six couples had practiced some form of contraception, and 57 percent had consulted a physician either in private practice, at a specialized family planning clinic or at a clinic offering family planning combined with other health services. Nine percent of women had consulted physicians in organized programs (clinics), while 48 percent had seen a private practitioner. There were significant differences, however, in source of service by income and ethnic grouping. Among couples below 150-percent-of-poverty, 12 percent of whites obtained contraception through organized programs, compared to 28 percent of nonwhites, and 41 percent of whites obtained services from a physician in private practice, compared to 20 percent of nonwhites. Above 150-percent-of-poverty, 23 percent of nonwhites used organized clinics, compared to only six percent of whites, and proportionately fewer nonwhites obtained services from a private physician. "Since the ratio of physicians in private practice to population is considerably lower in predominantly black neighborhoods than in white areas, many nonwhite couples may have few realistic alternatives to clinic services, whether or not they could theoretically afford private medical care," Jaffe said.

The study also found that organized programs were responsible for a substantially larger proportion of first prescriptions of the pill, IUD and diaphragm for low-income and nonwhite couples, and for a somewhat larger proportion of such prescriptions for couples married between 1966 and 1970, regardless of poverty status.

The increasing importance of organized programs is demonstrated by data on where pill and IUD users obtained their first prescription before or after 1969, the year in which organized programs began to expand rapidly with the infusion of federal funds. Only 11 percent of women who began to use pills or IUDs before 1969 obtained their first prescriptions through organized programs; after 1969, the proportion increased to 16 percent, including one-third of prescriptions among all poverty-status users. "After 1969," Jaffe reported, "the proportion of all white users introduced to pills and IUDs by organized programs doubled and, as of 1970, it included more than one-fourth of white poverty-status users. Thus, the expansion of organized programs in the last three years was accompanied by increased utilization of clinic services by whites. . . ." The proportion of first prescriptions secured by nonwhites from organized programs remained the same before and after 1969.

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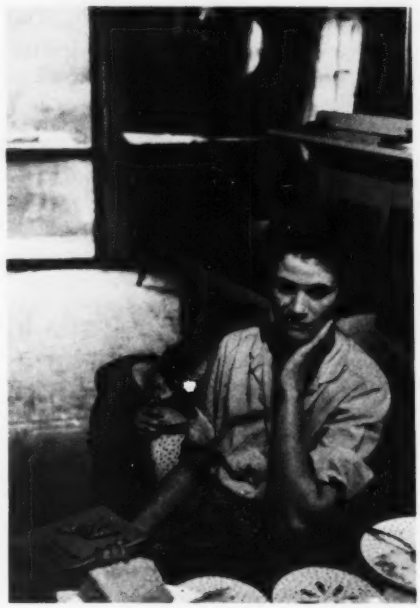

Ovulation

Six-Week Check Late For Contraception?

Ovulation may resume earlier than heretofore suspected following therapeutic abortion or normal childbirth, two recent studies indicate. The investigators suggest that contraception should be started early — as early as within two weeks after abortion; it should not be delayed until the onset of the first menstrual period following delivery. Indeed, it was found that a number of women were ovulating prior to six weeks postpartum — the traditional time for postpartum contraceptive prescription.

One study was conducted by Drs. E. Forrest Boyd and Emil G. Holmstrom, of the Southern California Permanente Medical Group and the Kaiser Foundation Hospital. Patients requesting therapeutic abortion from January 1 to June 30, 1971, and not planning to use hormonal contraception, were taught to keep a basal body temperature (BBT) graph and to maintain a record of the amount and duration of their bleeding. Complete contraceptive histories, including future plans, were taken. Patients were asked

to return on the first or second day of their first menstrual period following the therapeutic abortion. At that time, contraception was provided, and an endometrial biopsy was taken.

"If the endometrial biopsy showed that ovulation had occurred, the date of ovulation was calculated by subtracting 14 days from the onset of the current menses. . . . the [BBT] graphs were utilized as an adjunct," Drs. Boyd and Holmstrom reported in the *American Journal of Obstetrics and Gynecology*. The records of 72 of the 630 women who had had abortions were studied. Of the 72 women, 11 had not ovulated at the time of endometrial biopsy. "Sixty-one . . ., or 85 percent, ovulated prior to their first menstrual period, with all but one ovulating prior to the thirty-sixth postabortal day, well before the usual six-week checkup," the physicians said.

"The mean day was 22, with the earliest verified ovulation occurring on the tenth postabortal day," they pointed out. "For the first time, we have objective evidence that [women] should be supplied with contraception within 10 days after therapeutic abortion." They noted that, in some of the nonovulating patients, the biopsies were probably taken too soon for ovulation determination, at the time of vaginal bleeding misinterpreted as a menstrual flow.

It is of interest that among the 61 women who ovulated prior to their first menstrual period, eight percent had had prior elective abortions. None of the 11 nonovulating women had had a previous abortion.

The physicians concluded, "This brief study indicates that contraceptive advice should take into consideration the possibility that conception can occur in the second week after therapeutic abortion."

The second study, of 200 mothers in Chile from childbirth to first ovulation and to the first bleeding day, as related to breast-feeding, was reported in *Population Studies* by Drs. A. Perez, P. Vela, R. Potter and G.S. Masnick of the Catholic University of Chile. The investigators sought to learn the effects of differing histories of breast-feeding — full, partial and no breast-feeding — upon the time of first ovulation and the time of first postpartum menses. They noted:

> The times when mothers move from full to partial breast-feeding or suspend breast-feeding altogether have a large bearing on how quickly they resume ovulatory function. A second and very practical interest is the proportion of first cycles that are ovulatory. Unless this proportion is very low, the average woman cannot afford to wait until resumption of menstruation before initiating contraceptive precautions. The present study leads to a higher estimate of ovulatory first cycles than have most previous studies.

Patients were instructed to record their BBT and to return to a special postnatal clinic seven days after discharge from the hospital. Every seven days vaginal wall smears were taken, and around the fourth postpartum week serial study of the cervical mucus was initiated. Forty days after delivery every amenorrheic woman had an endometrial biopsy. Thereafter, all patients were seen weekly, at which time their BBT charts were studied, breast-feeding histories noted and vaginal wall smears and cervical mucus studies made. In addition, as long as amenorrhea persisted, an endometrial biopsy was performed every 30 days. Once a woman started menstruating, an endometrial biopsy was performed on either the twenty-sixth day of the cycle or the first day of bleeding, whichever occurred earlier. This procedure was repeated until the sixth postpartum cycle. Two groups of women were studied: 30 who did not breast-feed at all and 170 who breast-fed, partially or fully, for varying lengths of time.

The physicians reported that the 30 women who did not breast-feed averaged "only 49 days to full ovulation, with a standard deviation of but 12. . . . Among 170 [lactating] women . . ., no ovulations were recorded during the first 39 days postpartum, though seven [were] registered during days 40-42." Twelve women conceived during a first ovulatory cycle, despite lactation.

The physicians also noted that ovulation is "rare" before day 42, and is "infrequent" before day 60 in the presence of full breast-feeding. They added that breast-feeding status "affects the likelihood that the first cycle will be ovulatory." In studying the type of breast-feeding on the first bleeding day, it was found that ovulation preceded first menstruation in less than half the cases where there was full breast-feeding but in 90 percent of the cases after breast-feeding was suspended.

The study suggests that "if a woman has not ovulated by the time she suspends lactation, she may expect to do so within an interval averaging under six weeks."

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Choice of Sex Might Mean Fewer Children

Boys outnumber girls in couples' first-child preference, according to several surveys. When and if control of the sex of offspring becomes possible, the surveys indicate, there would be both a greater initial excess of males over females than at present, and smaller families.

Various cultures in the world prefer male children, Gerald E. Markle and Charles B. Nam, of the Department of Sociology, Florida State University in Tallahassee, point out in *Social Biology*. They cite one study of unmarried college students, in which 91 percent of the males and 66 percent of the females queried said they desired a boy, if they were to have only one child. The figures on a first-child preference were 60 percent for a boy, five percent for a girl and 34 percent with no preference.

Another college study, of 55 upperclassmen, showed that the students preferred 86 boys and 52 girls, representing a 65 percent greater demand for males over females. Yet another study indicated that when the first child born is a male, the "interval before a second child was conceived averaged three months longer than when the first child was a girl."

Markle and Nam conducted their own survey, receiving a return of 283 out of 438 questionnaires sent to groups of students at Florida State University, Florida Agricultural and Mechanical University, and Tallahassee Junior College. In reply to a question about how many children of each sex the students, ideally, would prefer to have, the answer was: 485 males to 390 females. Both men and women students overwhelmingly preferred their first child to be a boy.

Markle and Nam point out that there is already an excess of male babies at birth, with 105 males born for every 100 females. If couples could determine the sex of their children, "initially 122 males would be born for every 100 females."

In another number of *Social Biology*, demographer Nathan Keyfitz, quoting a recent study in Hull, England, points out that recently married couples there want 2.55 children. Because they want more boys than girls, however, "they will on the average actually attain 3.7 children." If they could control the sex of their offspring, Keyfitz points out, the mean number of children would go down to 2.55.

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Family Planning Job Opportunities

Position: Certified Nurse-Midwife
Agency: PRIDE in Logan County, Inc.
Location: Logan, W. Va.
Salary: $15,000
Job Description: Prenatal care, deliveries and postpartum checks in a family planning program.
Qualifications: Graduate of a qualified school of nurse-midwifery.
Contact: Sarah A. Fields, Director of Health Affairs, 118½ Stratton Street, Box 1346, Logan, W. Va. 25601

•

Position: Chief Family Planning Project Nurse
Agency: Norfolk Family Planning Project
Location: Norfolk, Va.
Salary Range: $8,784-$10,992
Job Description: Direct four nurses and two technicians, and participate as a team member in policy determination, implementation and evaluation of this ongoing public health project.
Qualifications: An MPH in nursing or similar graduate nursing degree with public health nursing experience in an area related to family planning.
Contact: Dr. H. W. Taylor, 1015 East Princess Anne Road, Norfolk, Va. 23504

•

Position: Family Planning Nurse Coordinator
Agency: Family Planning of Greater Lowell
Location: Lowell, Mass.
Salary Range: Commensurate with experience
Job Description: Coordinate clinic, follow-up activities and supervise workers. Assist health educator with training and community education.
Qualifications: R.N. with a B.A. in nursing. Public health and ob-gyn experience necessary.
Contact: Donna Morse, Project Director, Lowell General Hospital, 295 Varnum Avenue, Lowell, Mass. 01854

•

Position: Associate Regional Director, Mid-Atlantic Region
Agency: Planned Parenthood-World Population (PP-WP)
Location: Philadelpia, Pa.
Salary Range: $15,000-$18,000
Job Description: Plan, develop, implement, evaluate and monitor Planned Parenthood affiliates' ongoing programs and program expansion. Liaison between affiliates and national PP-WP headquarters. Develop techniques to reach rural poor; develop and conduct community education conferences and training workshops for professionals and paraprofessionals. Provide technical assistance in project development.
Qualifications: M.A. in social work or public health, five years' experience in program administration and implementation and three years of consultant experience.
Contact: Doris Bernheim, Assistant Director for Operations, Field Department, Planned Parenthood-World Population, 810 Seventh Ave., New York, N.Y. 10019.

•

Position: Executive Director
Agency: Planned Parenthood Association of Utah
Location; Salt Lake City, Utah
Salary Range: Approximately $12,000 per year
Job Description: Under the policy and direction of the State Planned Parenthood Board, is responsible for implementing family planning services.
Qualifications: B.A. in psychology, public administration, or related field with at least three years experience in a progressively responsible administrative capacity in a program providing direct services to the public and at least two years serving low-income individuals. Experience may be substituted on a year-to-year basis for the required education.
Contact: Helen Henderson, 951 Signora Drive, Salt Lake City, Utah 84116.

•

Position: Director of Training
Agency: Family Planning Resources Center, Planned Parenthood of New York City
Location: Brooklyn, N.Y.
Salary Range: From $17,000 depending on qualifications and experience
Job Description: Develop new training programs and coordinate and integrate all current training programs; hire, train and supervise project coordinators and core training staff; serve on City-Wide Advisory Council for Family Living (including sex education); coordinate activities with other agencies providing complementary services within the city.
Qualifications: Graduate degree in one of the following: human relations, education, human sexuality, social work, health education or guidance and counseling; experience in supervision and program planning; knowledge of new developments and techniques in training and intensive training experience.
Contact: Jerim Klapper, Director, Family Planning Resources Center, 44 Court Street, Brooklyn, N.Y. 11201

•

Position: Assistant Directors for Fund Raising
Agency: Planned Parenthood-World Population
Location: Western Region, San Francisco, Calif.; Southwest Region, Austin, Tex.; Midwest, Kansas City, Mo.; Great Lakes, Detroit, Mich.
Salary Range: $14,000-$20,000
Job Description: Fund raising consultant to affiliates.
Qualifications: Tact and ability to work with volunteers, boards and committees. Experience in fund raising and fund raising techniques is essential.
Contact: Jess Speidel, Director of Resources, Planned Parenthood-World Population, 810 Seventh Avenue, New York, N.Y. 10019

•

Position: Program Director
Agency: Planned Parenthood-World Population, Alameda, San Francisco
Location: Oakland, Calif.
Salary Range: $15,000-$17,000, negotiable
Job Description: Develop and implement $800,000 program designed to prevent unplanned births. The agency, which now serves about 2,000 patients a month, is committed to assisting other agencies to provide services and programs that are conducive to meeting our goals, and the program director will be expected to develop a working relationship with other agencies.
Qualifications: M.A. in public health education, hospital administration, or social work preferred, or at least five years' experience in health or welfare agencies. Knowledge of principles and practices of community organization and planning. Must write clearly and concisely; know budgeting procedures and control.
Contact: E. P. Stephenson, Executive Director, Planned Parenthood-World Population of Alameda, San Francisco, 476 West MacArthur Boulevard, Oakland, Calif. 94609

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Position: Medical Director
Agency: Planned Parenthood of Wisconsin
Location: Milwaukee, Wis.
Salary: Open
Job Description: Supervise medical aspects of Planned Parenthood operation; coordinate liaison with clinic staff, medical advisory committee and medical community; conduct education program.
Qualifications: M.D., licensed to practice ob-gyn in Wisconsin, some medical school affiliation preferred.
Contact: Ms. Margaret Miller, Planned Parenthood of Wisconsin, 1135 West State Street, Milwaukee, Wis. 53233

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